STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E376	A. BUILDING 00 B. WING	01/10/2012 12:00:0

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAKERS REST HAVEN	305 E NORTH ST BOONVILLE, IN47601

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F0000	This visit was for the Recertification and State Licensure Survey. Survey Dates: January 3, 4, 5, 6, 9, and 10, 2012 Facility number: 000450 Provider number: 15E376 AIM number: 100273890 Survey team: Terri Walters RN-TC Martha Saull RN Carole McDaniel RN (1/3, 1/4, 1/5, 1/9, 1/10, 2012) Census bed type: NF: 39 Total: 39 Census Payor type: Medicaid: 30 Other: 9 Total: 39 Stage 2 Sample:14 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 1/13/12 by Suzanne Williams, RN	F0000	By submitting the response to the 2567 we are not admitting to any allegations. We reserve the right to contest these findings or allegations as a part of any proceeding and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective February 9, 2012 to the state finding of the Recertification and State Licensure Survey conducted on January 3 thru 10, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			

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	Based on interview and record review, the facility failed to ensure a physician was notified of a resident's refusal to wear a hand splint for 1 of 3 residents reviewed with hand splints in a stage 2 sample of 14. . Resident #30 Findings include: The clinical record of Resident #30 was reviewed on 1/09/12 at 8 A.M. Diagnoses included, but were not limited to, the following: dementia and osteoporosis. A Joint Mobility Assessment was completed on 11/28/11. This form indicated the following: "...last 2 fingers rt (right) hand chronically drawn..." A physician order, dated 11/28/11, indicated the following for the resident: "Pt (patient) to wear R (right) hand orthotic x 3 hours throughout the day. Restorative aide to donn orthotic in the am (sic) (morning) 7 days a week, to be reapplied if needed." Notes from the restorative aide were reviewed for the 12/30/11 entry. This entry indicated the following: "Resident still taking off splint as soon as applied. Recommend stopping." This entry was	F0157	The physician for the resident identified as resident # 30 has been notified of the residents's refusal to wear the splint. A new physician's order has been obtained related to the wearing of the hand splint. Any repeated non-compliance of the physician' order related to the wearing of the hand splint will be promptly reported to the physician. A facility wide review of physician's orders has been completed to identify any other residents who are consistently being non-compliant with following spling usage. No other residents were identified. A mandatory inservice was provided to all nursing staff on reporting any resident's non-compliance with following physician's orders for splint usage. During the inservice the nursing assistants were directed to report these acts of non-compliance to their charge nurse and the charge nurses were directed to report the non-compliance to the resident's physician for further directions/instructions. A Quality Assurance Tool has been developed and implemented to monitor physician notification of resident's non-compliance with splint usage. The tool includes observations of the splint schedule being followed, documentation to support the splint schedule is being followed and prompt physician notification	02/09/2012

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	signed by the Restorative CNA and also the Restorative LPN. A care plan, dated 1/5/12 addressed "Change in ROM (range of motion) and splint." Interventions included, but were not limited to, the following: "splint to be on rt hand 1 hr (hour) in A.M. and 1 hour in P.M. (afternoon). Enc (encourage) to leave in place." On 1/9/12 at 9 A.M., the resident's "Nursing Rehab (Rehabilitation)/Functional Maintenance Plan" was reviewed. This form was dated December 2011. This form indicated the following: "Goal: To prevent decline in BUE (bilateral upper extremity) mobility/ROM (Range of motion) and R (right) hand ROM. Approaches:...apply hand splint to r (right) hand...encourage res to wear for 2 hrs (hours) in A.M. and 2 hrs in P.M..." This form had documented on 1/4/12 by the Restorative LPN, "...are changes recommended to the approaches (yes) is checked. CHECK WHAT NO IS...." The Restorative LPN noted the following comment "Decrease time/freq (frequency) of splint r/t (related to) non compliance. Res removes and throws away." On 1/9/12 at 10 A.M., the clinical record		if the resident refuses to wear the splint as ordered. This tool wll be completed by the Director of Nursing or designee weekly for four weeks, then monthly for 6 months. The outcomes will be reviewed at the quarterly Quality Assurance meeting to determine of any additional action is warranted.	

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	of Resident #30 was again reviewed. Nurses notes, dated 1/5/12, indicated at 1030 (10:30 A.M.) "...MD responded to monitor and ..." Documentation was lacking of physician notification of the resident's refusal to wear the right hand splint and/or documentation of the physician's order to discontinue the splint. On 1/9/12 at 1:30 P.M., the DON (Director of Nursing) was interviewed. She indicated the Restorative Aide was to put the splints on but the resident was not on a restorative program. The DON indicated the Restorative Aide (RA) told the Restorative LPN that the resident didn't leave the right hand splint in place. The DON indicated that Restorative LPN stated she decreased the time/frequency of the splint application to 1 hour in the morning and 1 hour in the P.M. The DON stated the Restorative LPN stated she mentioned to the physician, when she spoke with him regarding another issue with the resident on 1/5/12, that the resident didn't keep her splint on but didn't document this information. The DON stated the Restorative LPN indicated the physician told her to discontinue the splint. The DON indicated the Restorative LPN didn't discontinue the splint because she thought it was too extreme.			

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	3.1-5(a)(2)			
F0161 SS=B	The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.			

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	Based on interview and record review, the facility failed to have a surety bond of security coverage for 3 of 3 residents having funds in accounts with the facility. Resident #9 Resident #17 Resident #23 Findings include: On 1/10/12 at 10:30 A.M., the Administrator was interviewed regarding surety bond coverage. Documentation was lacking to identify the facility had a surety bond. The Administrator indicated bond coverage could not be found and attributed the problem to multiple changes of ownership and management. The facility resident accounts were reviewed on 1/10/12. There were 3 residents with accounts, Resident #9, Resident #17, and Resident #9. The total sum of the amount in the 3 accounts was $315.19. 3.1-6(j)	F0161	A surety bond has been obtained for those resdients identified as resident #9, resident #17 and resident #23, all of which have resident trust funds. The facility has obtained a surety bond that exceeds the total amount of funds in the resident's trust account. The Administator will monitor the amount of funds each month to ensure that the surety bond is adequate to cover the amount of funds in resident trust accounts. This monitoring is ongoing. An audit will be conducted annually to ensure that facility meets regulatory requirements in providing a surety bond the exceeds the total dollars being kept in the resident trust account.	02/09/2012

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F0164 SS=E	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.			

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	Based on observation and interview, the facility failed to provide restorative range of motion services out of public view for 4 of 9 residents being provided range of motion services. Resident #13 Resident #4 Resident #10 Resident #1 Findings include: On 1/3/12 at 11:19 A.M., Restorative Aide (RA) #1 was observed in the central lounge of the facility providing range of motion exercises for Resident #13. The resident appeared debilitated and was reclined in a geri chair. The lounge was the room into which all visitors, to the facility, entered and the walkway through which they entered. On 1/4/12 at 10:30 A.M., Resident #1 was observed receiving range of motion exercises from RA #1 in the same lounge side alcove where visitors walked directly in front of the resident receiving care as they came through the walkway. On 1/09/12 at 9:07 A.M. RA #1 was performing range of motion exercises on Resident #1 in the lounge alcove. Resident #39 was sitting 2 feet away in the alcove, watching the process. Resident #1 indicated her right heel was hurting. RA #1 removed her shoe and	F0164	The residents identified as residents #13, #4 #10 and #1 are now receiving their range of motion in a private setting. In addition resident # 1's knee/leg brace is applied in a private setting and no socks and shoes are removed in a public area. All residents on restorative range of motion programs are now receiving their range of motion in a private setting. The restorative aide was inserviced on providing range of motion excercises, anticontracture devices, shoe and sock removal and brace applications for residents in a private setting. All staff were re-inserviced on #3.4 of the Resident's Bill of Rights Policy that addresses the resident's right to privacy when receiving medical treatment and personal care. A Quality Assurance tool has been developed and implemented to monitor compliance of providing restorative range of motion in a private setting. The tool includes a visual observation of residents receiving restorative range of motion in a private setting. This tool will be completed by the Director of Nursing or designee for four weeks then monthly for six months. The outcomes will be reviewed at quarterly Quality Assurance meeting to detremine if additional action/review is warranted.	02/09/2012

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	sock to expose the area and lifted her leg and foot for inspection. She redressed the limb, completed the exercises and applied a knee/leg brace to the right leg. RA #1 exercised the upper extremities, arms and fingers and placed an anticontracture device in the left hand. On 1/10/12 at 10:40 A.M., debilitated Resident #4 was observed in the lounge in a reclining geri chair receiving range of motion exercises from RA#1. The RA was interviewed at 10:50 A.M. She indicated she had always provided range of motion care to residents in the lounge stating, "Whoever was in the lounge, I did them there." She indicated there were limited spaces to take the residents for the service but could provide it in their rooms. She stated her routine was to do range of motion care for 4 of the 9 residents receiving it, in that lounge. They were Resident #13, Resident #4, Resident #1, and Resident #10 (not observed). On 1/10/12 at 10:55 A.M., Director of Nursing was interviewed regarding related policies. She indicated the facility practice expectations were for treatments and individual care to be provided in private; however, staff had not identified range of motion services as personal care			

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	being rendered. She indicated the services would be performed in non public areas now. Written policy was not provided for review. 3.1-3(p)(2)			
F0246 SS=A	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.			

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	Based on observation and interview, the facility failed to provide table heights at appropriate usage levels for 3 of 18 residents observed eating of the 23 Residents who usually ate in the dining room. Resident #21 Resident #5 Resident #35. Findings include: On 1/04/12 throughout the noon meal and on 1/09/12 throughout the breakfast meal, table heights were above eating level for 3 residents. Resident #21 was being served meals at a height above her nose level. Resident # 5 and Resident 35 were both being served meals at the level of their collar bones. On 1/09/12 at 8:45 A.M. the Administrator was informed of the problem. She indicated none of the available dining tables has adjustable heights but the problem would be addressed. 3.1-3(v) 3.1-19(w)(5)	F0246	Immediate adjustments were made in resident positioning, dining table height and seat cushioning for resident # 21, # 5 and #35. An audit was completed on all residents who dine in the dining room to ensure that the table height is appropriate. In addition all new admissions or additional residents who decide to eat in the dining room will be assessed as it relates to proper dining table height. A mandatory inservice has been conducted fo all nursing employees on appropriate table height. The facility has appointed the restorative aide to monitor appropriate table height for all residents who choose to dine in the dining room on a daily basis. The restorative aide has been directed to report any areas of concern promptly to the Director of Nursing or Administrator for further evaluation and assessment. This monitoring is ongoing.	02/09/2012
F0253 SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.			

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	Based on observation and interview, the facility failed to ensure chairs in the lobby area were clean and in good repair all days of the survey. This had the potential to affect 39 of 39 residents. Findings include: On 1/3/12 at 9:30 A.M., the initial tour of the lobby area had begun. Four cloth upholstered wing back chairs were observed. Two blue flowered upholstered wing back chairs were observed to have thread barren areas on both arms and one of the seats of the chair. These chairs were heavily soiled through out the upholstered areas. The two beige cloth upholstered wing chairs had an accumulated layer of dark soil through out the upholstered areas of the chairs. All 4 chairs had a large amount of marred and/ or scratched areas of the wooden legs of the chairs. On 1/10/12 at 10:35 A.M., the Administrator was made aware of the soiled chairs in the lobby. She indicated the beige chairs would probably have to be replaced. 3.1-19(f)	F0253	The four lobby chairs identified during the days of the survey have been replaced. All other lobby furniture has been assessed for stains and needed repair. An inservice was conducted for all housekeeping staff related to the condition of furniture. The housekeeping staff was directed during the inservice that during their daily cleaning of the facility to report any damaged furniture to the housekeeping supervisor promptly. The housekeeping supervisor will in turn report damaged furniture to the maintenance director and/or administrator for repair or replacement. The housekeeping supervisor has added lobby furniture to her monthly furniture inspection. This report will be sent to the administrator for review and action as needed. This process is ongoing.	02/09/2012

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F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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	A. Based on interview and record review, the facility failed to ensure a resident had preventative interventions in place to prevent falls for 1 of 2 residents reviewed for falls of 2 residents who met the criteria for falls/accidents in a stage 2 sample of 14. Resident #14 B. Based on observation and interview, the facility failed to ensure 8 of 48 mattresses safely fit the bed frames of 48 occupied beds in the facility. This deficient practice potentially affected 8 residents. Findings include: A. On 1/5/12 at 9 A.M. the clinical record of Resident #14 was reviewed. Diagnoses included, but were not limited to, the following: mixed dementia, Alzheimer-vascular type with behavioral disturbances. The resident was admitted to hospice services on 12/8/11 with a diagnosis of Alzheimers. The most recent MDS (minimum data set assessment) dated 12/5/11, indicated the resident was 65 inches tall (5 feet 5 inches) and weighed 145 lbs; total dependence for bed mobility and transfers; and cognition was severely impaired; non ambulatory; and no	F0323	A bed safetly assessment has been competed on resident # 14 as a measure to ensure safety. All 8 mattresses in excess of 4 3/4 inch gap between headboard or footboard were immediately padded to eliminate the gap. A house wide audit was conducted to ensure all mattresses properly fit the bed frame in accordance with regulatory guidelines. In addition the facility has spoken with hospice staffing and requested that any change in bed surfaces require a bed safety assessment and the approval of the Administrator or Director of Nursing prior to changing the bed surface. Longer mattresses were obtained to ensure a permanent solution to the mattress gap. An inservice was provided for the maintenance director nursing staff on mattress/bed frame safety. A new procedure was implemented in that a change in bed or bed surface requires the evaluation by the maintenance director to ensure that the mattress fits the bed frame in accordance with regulatory guidelines. Bed/mattress assessment has been added to the preventative maintenance schedule to be completed monthly. This monitoring is ongoing.	02/09/2012

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	15E376	A. BUILDING 00 B. WING	01/10/2012 12:00:0

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	impairment in range of motion. A fall risk assessment, dated 9/9/11, had a total score of 10. The form indicated a total of 10 or over indicated a high risk. Nurses notes, dated 12/11/11 at 0020 (12:20 A.M.) indicated the following: "Upon making rounds found resident lying on floor. Resident awake and conscious...has a large knot on back of head..." A plan of care addressing the problem of Falls, indicated an intervention of "bed switched for tonight off air mattress." This intervention was dated 12/11/11. A Fall risk assessment, dated 12/11/11 indicated a total score of 12 (after the fall - high risk). A Side rail assessment dated 12/11/11, indicated the following: "Air mattress with bolsters applied today d/t (due to) res (resident) on floor. Current air mattress still causes rippling effect and shifts him (sic) toward edge of bed. Bil (bilateral) 1/2 SR (side rails) would enable her to have air mattress more safely and will not limit mobility d/t (due to) res (resident) dependent on staff for all mobility." Another note, dated 12/11/11, indicated			

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	"Air mattress dc'd (discontinued) and Rest Q Mattress in place. Therefore 1/2 rails dc'd." A copy of the manufacturer's instructions for the bed from which the resident fell from, was obtained from the DON on 1/6/12 at 11:20 A.M. These instructions included, but were not limited to, the following under precautions: "...The use of bedframe siderails in conjunction with any select air low air loss mattress system should be determined based on facility protocol applicable laws and regulations, and individual user safety considerations. Bed frame side rail usage is not a requirement for the functional operation of any Select Air product, but individual safety requirements and/or facility protocol may dictate that side rails be utilized. A physician order, dated 12/12/11, indicated the following: "D/C (discontinue) low air loss mattress. Start Rest Q Mattress when available..." On 1/9/12 at 10 A.M. the DON was interviewed. She indicated the mattress the resident had in place when she fell, was "billowy" and the resident was dependent for care. At this time she reviewed the resident's clinical record and			

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	indicated documentation was lacking regarding the assessment of the resident in regard to the use of devices designed to prevent the resident from falling out of bed. The DON provided documentation from the Hospice nurse, dated 1/9/12, a late entry from 12/9/11. This documentation indicated "Admitted to (name of hospice) with (mattress name) order...Pt (patient) unable to follow commands...generalized weakness and debilitation...HRN (hospice registered nurse) and DON (Director of Nursing) also discussed placing full rails on bed d/t (due to) mattress material being 'slick.' It was decided between pt's lethargy and generalized weakness, it would not be necessary." The DON was interviewed on 1/10/12 at 9:20 A.M. She indicated there should have been a more detailed assessment regarding the resident needing or not needing devices in place on the resident's bed to prevent falls. She indicated the rental company came and set up the bed and they are trained to do this. She indicated the rental company inserviced the staff working at that time as to how the bed worked. The DON stated that immediately after the resident fell out of the bed, they changed the resident to a			

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	regular bed, which was empty at that time. The DON stated she and the hospice nurse did discuss the possibility of side rails, 1/2 side rails for the resident, and the hospice nurse said she had residents in homes on these mattresses and had never had a problem. The DON indicated she (the DON) thought the resident might have needed 1/2 rails but the hospice nurse has more experience at this. She said this facility had never had this type of mattress before. The DON said the rental company comes and sets up the settings for the mattresses. The DON indicated there should have been a more detailed assessment for this mattress regarding the resident movement. She indicated she didn't know if the aides put the resident too close to the edge or if the billowing of the mattress moved the resident over to the edge. On 1/10/12 at 11:50 A.M. the DON was interviewed. She indicated the mattress that the resident fell out of bed on has what were referred to as "risers" running along either side, the length of the mattress. She indicated while lying in bed, the resident appeared to lie below the level of the "risers." The DON indicated the resident had not had any falls for approximately 6 months and the last time the resident fell was from her bed and she			

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	"reached" out and fell out of bed. The DON indicated immediately after the fall, the resident was placed in a regular bed. The next day a "IQ low air loss" mattress was given to the resident. The DON stated this bed appeared to "swallow the resident up" so was later that day, replaced with the current mattress, a Rest Q Mattress. B. During tour of the facility on 1/3/12 at 9:30 A.M., eight beds in the facility were observed with the following concern: There was over a 4 3/4 inch gap between the headboard to the head of the mattress. The following measurements were obtained when the head of the bed was flat, by the maintenance man on 1/3/12 at 11 A.M. The following beds had inappropriately fitting mattresses: Room 22a = 6 inches; Room 22B = 5 1/2 inches; Rm 18 = 6 inches; Room 27A = 5 inches; Room 27B = 5 1/2 inches; Room 15B = 5 inches; Room 13A = 5 inches; Room 3B = 7 1/2 inches. On 1/3/12 at 2:10 P.M., the Administrator was made aware of the gaps between mattress and headboard and/or foot of bed			

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	totaling over 4 3/4 inches. On 1/3/12 at 2:10 P.M. the Administrator was interviewed. She indicated they would immediately fix the problem by putting blanket and/or pillows in the space between the head of the bed and the headboard. The Administrator indicated the mattresses that are affected were those that they had from rented beds. She indicated they would obtain mattresses that better fit these beds as soon as possible. The document "Guidance for Industry and FDA (Food and Drug Administration) Staff, Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" dated 3/10/06 included, but was not limited to, the following: "FDA is therefore using a head breadth dimension of...4 3/4 inches as the basis for its dimensional limit recommendations..." 3.1-45(a)(1) 3.1-45(a)(2)			

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			

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	Based on observation and interview, the facility failed to ensure daily nursing staffing posting was easily identified as staffing, and displayed in a clear and readable manner. This had the potential to affect 39 of 39 residents and their visitors. Findings include: On initial tour of the building on 1/3/12 at 9:30 A.M., the nursing staffing posting was observed on a wall across from the nursing station.. This nursing staff posting was not at wheelchair height but was located at approximately six foot height on the wall. The printed numbers of the staffing were approximately 1/8 of an inch in height. This staffing form did not identify the information displayed as nursing staffing information. The nursing staffing posted remained in this format all days of the survey. On 1/10/12 at 10:30 A.M., the Administrator was made aware of the daily nursing staffing information was not easily readable for residents in a wheelchair. The Administrator was also made aware the staffing information was not easily identified as the daily nursing staffing information of the facility. The	F0356	The daily staffing form has been revised to make the form easier to read and has been posted at a level easily read by wheelchair bound residents. The Director of Nursing has been advised of the staff posting requirements. The Director of Nursing or Designee will post the form each day. All staff have been inserviced in the revised form and proper posting requirements. A quality assurance tool has been developed and implemented to monitor the daily staffing posting to ensure that it meets all regulatory guidelines. This tool will be completed by the Administrator and/or designee weekly for four weeks, then monthly for 6 months. The outcomes will be reviewed at the quarterly Quality Assurance meeting to determine of any additional action is warranted.	02/09/2012

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	Administrator indicated at this time the information would be moved to a lower section of the wall. She then moved the staffing form to a lower section of the wall. 3.1-13(a)			
F0425 SS=F	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	Based on observation, interview and record review, the facility failed to ensure the medication refrigerator was maintained at recommended temperatures for medications housed in the refrigerator and/or removed expired medications from stock for 1 of 1 medication room tour, which had the potential to affect all 39 residents. Findings include: On 1/5/12 at 9 45 A.M. the medication room was toured with the Director of Nursing (DON) and LPN #1. LPN #1 read the current temperature of the medication refrigerator at 30 degrees (F) Fahrenheit from the thermometer located inside the refrigerator. The refrigerator contained the following medications: Novolog Insulin 70/30, 2 vials, one opened; 1 vial Novolin R (regular) insulin, unopened; Humalog 75/25, 2 vials opened; The above liquid medications did not appear frozen. Six boxes of PPD (purified protein derivative). The Refrigerator Temp (temperature) monitoring log for January 2012 was taped to the front of the refrigerator. The log had temperatures ranging from 32 degrees (on 1/4/12) to 40 degrees.	F0425	The Refrigerator Temp Monitoring log has been revised and now states the same temperature range as the Medication Storage policy. The expired Humalog in the refrigerated EDK was replaced by pharmacy. A new procedure has been implemented in which the East nurses checks and documents the expiration dates of the refrigerated EDK at change of each shift. All nurses have been inserviced in this new procedure. Night shift nursing staff have the responsibility of checking the refrigerator temperatures. They have been inserviced on where to document on the revised log. The Director of Nursing/or designee will review the temperature monitoring log and Medication refrigerator temp log weekly for 4 weeks. The pharmacy will check for expired medications in the refrigerated EDK and for correct medication refrigerator temps during the routine monthly medication review. This procedure will be ongoing.	02/09/2012

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	Directions printed on the log indicated the following: "Keep temp between 32 - 41 degrees or report to maintenance." On 1/5/12 at 1:45 P.M. the DON provided a copy of the December 2011 temperature log. This log was completed and had temperatures ranging from 36 degrees to 41 degrees. On 1/5/12 at 1:45 P.M. the DON provided a current copy of the facility policy and procedure for "Medication Storage in the facility." This policy included, but was not limited to, the following: "...Medications requiring "refrigeration" or "temperatures between... (36 degrees F) and...46 degrees F are kept in a refrigerator with a thermometer to allow temperature monitoring...Outdated...medications...are immediately removed from stock..." The facility's current 2012 Nurses Drug Handbook was reviewed on 1/6/12 at 10 A.M. This book indicated the following storage temperatures for the following medications: Novolin Regular Insulin, Novolin 70/30 Insulin: Store below 86 degrees Fahrenheit, do not freeze; Novolog Insulin: 36- 46 degrees F, do not freeze; Humalog refrigerate 36 - 46			

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	degrees F; PPD store between 36 - 46 degrees F; The EDK (Emergency Drug Kit) was observed in the refrigerator. A form in the front of the EDK has a log of the contained medications with the expiration dates. On the log, was listed Humalog 75/25 with an expiration date of 11/11. The DON opened the box of Humalog 75/25 (which was previously sealed) and the bottle listed the expiration date of 11/11. The DON stated no one in the facility is currently on this medication. On 1/10/12 at 1:11 P.M. the DON was interviewed. She indicated they had just changed pharmacies and the pharmacy was to check the expiration dates of the medications in the EDK. 3.1-25(e)(3)			